FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041780

Facility Name: ROSE GARDEN CONVALESCENT CENTER

Address: 1629 GARDNER LANE (Number) PEORIA HEIGHTS (City) 61614 (Zip Code)

County: PEORIA

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-4069174

Date of Initial License for Current Owners: 03/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) SHERWIN I. RAY
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Previe

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	55	Skilled (SNF)	55	20,130	1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)	55	20,130	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,260	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,724		1,905	3,629	8
9	SNF/PED					9
10	ICF	23,920	2,170		26,090	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,644	2,170	1,905	29,719	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 73.82%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 1905

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

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IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CI # 0041780 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	153,271	13,011	4,250	170,532		170,532	0	170,532			1
2	Food Purchase		109,917		109,917		109,917	(783)	109,134			2
3	Housekeeping	89,024	15,716	0	104,740		104,740	0	104,740			3
4	Laundry	26,880	10,601	65	37,546		37,546	0	37,546			4
5	Heat and Other Utilities			61,892	61,892		61,892	245	62,137			5
6	Maintenance	30,489	28,106	20,062	78,657		78,657	3,152	81,809			6
7	Other (specify):*			11,028	11,028		11,028	0	11,028			7
8	**TOTAL General Services**	299,664	177,351	97,297	574,312		574,312	2,614	576,926			8
	B. Health Care and Programs											
9	Medical Director			7,188	7,188		7,188	0	7,188			9
10	Nursing and Medical Records	831,881	57,389	2,104	891,374		891,374	14,176	905,550			10
10a	Therapy	65,365	1,393	85,018	151,776		151,776	(3,600)	148,176			10a
11	Activities	37,707	874	0	38,581		38,581	0	38,581			11
12	Social Services	0		2,687	2,687		2,687	0	2,687			12
13	Nurse Aide Training			0				0				13
14	Program Transportation			0				0				14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	934,953	59,656	96,997	1,091,606		1,091,606	10,576	1,102,182			16
	C. General Administration											
17	Administrative	45,162		113,000	158,162		158,162	(47,365)	110,797			17
18	Directors Fees			0				0				18
19	Professional Services			157,403	157,403		157,403	(100,341)	57,062			19
20	Dues, Fees, Subscriptions & Promotions			25,637	25,637		25,637	(2,480)	23,157			20
21	Clerical & General Office Expense	108,057	10,268	77,244	195,569		195,569	(14,399)	181,170			21
22	Employee Benefits & Payroll Taxes			193,343	193,343		193,343	0	193,343			22
23	Inservice Training & Education			0				575	575			23
24	Travel and Seminar			1,093	1,093		1,093	64	1,157			24
25	Other Admin. Staff Transportation			3,318	3,318		3,318	726	4,044			25
26	Insurance-Prop.Liab.Malpractice			58,664	58,664		58,664	2,159	60,823			26
27	Other (specify):*			0				15,030	15,030			27
28	**TOTAL General Administration**	153,219	10,268	629,702	793,189		793,189	(146,031)	647,158			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,387,836	247,275	823,996	2,459,107		2,459,107	(132,841)	2,326,266			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Previe

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CI # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			5,345	5,345		5,345	118,240	123,585			30
31	Amortization of Pre-Op. & Org.			3,554	3,554		3,554	0	3,554			31
32	Interest			59,481	59,481		59,481	253,608	313,089			32
33	Real Estate Taxes			70,359	70,359		70,359	0	70,359			33
34	Rent-Facility & Grounds			358,335	358,335		358,335	(355,069)	3,266			34
35	Rent-Equipment & Vehicles			28,353	28,353		28,353	(6,415)	21,938			35
36	Other (specify):*							0				36
37	TOTAL Ownership			525,427	525,427		525,427	10,364	535,791			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		75,757	97,172	172,929		172,929	(27,365)	145,564			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			60,390	60,390		60,390	0	60,390			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		75,757	157,562	233,319		233,319	(27,365)	205,954			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,387,836	323,032	1,506,985	3,217,853	0	3,217,853	(149,842)	3,068,011			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Previe

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(18,396)	30		9
10	Interest and Other Investment Income	(24)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(783)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(189)	21		18
19	Entertainment	0	20		19
20	Contributions	(107)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(1,258)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(1,812)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	(3,892)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (26,461)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(123,381)	SCHED	34
35	Other- Attach Schedule	0	TTACHED	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (123,381)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (149,842)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Previe

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.
The amounts in columns F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name ROSE GARDEN CONVALESCENT CENTER

IDPH 0041780

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.				
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(782)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	2	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0
6	**Rented Facility Space**	0	34	**Line 6**	(3,892)
7	**Sale of Supplies to Non-Patients**	0	10	**Line 7**	0
8	**Laundry for Non-Patients**	0	4	**Line 8**	(4,870)
9	**Non-Straightline Depreciation**	(16,396)	30	**Line 9**	0
10	**Interest and Other Investment Income**	(24)	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	0	2	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(783)	2	**Line 12**	0
14	**Non-Care Related Interest**	0	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 15**	0
17	**Non-Care Related Fees**	0	20	**Line 16**	0
18	**Fines and Penalties**	(189)	21	**Line 17**	0
19	**Entertainment**	0	20	**Line 18**	0
20	**Contributions**	(107)	20	**Line 19**	0
21	**Owner or Key-Man Insurance**	0	22	**Line 20**	(3,127)
22	**Special Legal Fees & Legal Retainers**	0	19	**Line 21**	(730)
23	**Malpractice Insurance for Individuals**	0	26	**Line 22**	0
24	**Bad Debt**	0	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(1,258)	20	**Line 24**	0
26	**Income & IL Personal Property Replacement T**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 26**	0
28	**Yellow Page Advertising**	(1,812)	20	**Line 27**	0
29	**Non-Paid Workers**	0	0	**Line 28**	(5,304)
30	**Donated Goods**	0	0	**Line 29**	(8,940)
31	**Amortization Expense**	0	0	**Line 30**	(19,586)
32	DEFERRED MAINTENANCE	(3,892)	6	**Line 31**	0
33				**Line 32**	(84)
34				**Line 33**	0
35				**Line 34**	0
36				**Line 35**	0
37				**Line 36**	0
38				**Line 37**	(18,430)
39				**Line 38**	0
40				**Line 39**	0
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	0
46				**Line 45**	(20,469)

Print Other Adjustment

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(783)	0	0	0	0	0	0	0	0	0	0	(783)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	245	0	0	0	0	0	0	0	0	245	5
6	Maintenance	(3,892)	0	7,044	0	0	0	0	0	0	0	0	3,152	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,675)	0	7,289	0	0	0	0	0	0	0	0	2,614	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	14,176	0	0	0	0	0	0	0	0	14,176	10
10a	Therapy	0	(25,155)	21,555	0	0	0	0	0	0	0	0	(3,600)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	(25,155)	35,731	0	0	0	0	0	0	0	0	10,576	16
	C. General Administration													
17	Administrative	0	(77,000)	29,635	0	0	0	0	0	0	0	0	(47,365)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(102,300)	1,959	0	0	0	0	0	0	0	0	(100,341)	19
20	Fees, Subscriptions & Promotions	(3,177)	0	697	0	0	0	0	0	0	0	0	(2,480)	20
21	Clerical & General Office Expenses	(189)	(48,400)	34,190	0	0	0	0	0	0	0	0	(14,399)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	575	0	0	0	0	0	0	0	0	575	23
24	Travel and Seminar	0	0	64	0	0	0	0	0	0	0	0	64	24
25	Other Admin. Staff Transportation	0	0	726	0	0	0	0	0	0	0	0	726	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,159	0	0	0	0	0	0	0	0	2,159	26
27	Other (specify):*	0	0	15,030	0	0	0	0	0	0	0	0	15,030	27
28	**TOTAL General Administration**	(3,366)	(227,700)	85,035	0	0	0	0	0	0	0	0	(146,031)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(8,041)	(252,855)	128,055	0	0	0	0	0	0	0	0	(132,841)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(18,396)	131,288	5,348	0	0	0	0	0	0	0	0	118,240	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(24)	253,096	536	0	0	0	0	0	0	0	0	253,608	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(358,335)	3,266	0	0	0	0	0	0	0	0	(355,069)	34
35	Rent-Equipment & Vehicles	0	0	(6,415)	0	0	0	0	0	0	0	0	(6,415)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(18,420)	26,049	2,735	0	0	0	0	0	0	0	0	10,364	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(93,141)	65,776	0	0	0	0	0	0	0	0	(27,365)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Cent**	0	(93,141)	65,776	0	0	0	0	0	0	0	0	(27,365)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(26,461)	(319,947)	196,566	0	0	0	0	0	0	0	0	(149,842)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe ROSE GARDEN CONVALESCENT CENTEI # 0041780 Report Period Beginning 01/01/2000 Ending: 12/31/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	NILES	MGMT/CLERICAL
SEE ATTACHED SCHEDULE				ROSE GARDEN CARE CENTER LLC		
					NILES	REAL ESTATE
				CAREPLUS REHABILITATIVE SERVICES		
					NILES	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	Amount	4	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
V	17	MANAGEMENT FEES	77,000		CAREPLUS MGMT INC	6	6	(77,000)	1	-77000
V	19	ADMIN. CONSULTANT FEES	93,500		" "			(93,500)	2	-93500
V	19	DATA PROCESSING FEES	8,800		" "			(8,800)	3	-8800
V	21	CLERICAL FEES	48,400		" "			(48,400)	4	-48400
V									5	
V									6	
V	24	RENT	358,335		ROSE GARDEN CARE CENTER LLC			(358,335)	7	-358335
V	20	RL DEPRECIATION			" "		131,288	131,288	8	131288
V	22	INTEREST			" "		253,096	253,096	9	253096
V									10	
V									11	
V	10a	THERAPY SERVICES	25,155		CAREPLUS REHABILITATIVE SERVICE			(25,155)	12	-25155
V	39	ANCILLARY THERAPY	93,141		" "			(93,141)	13	-93141
Total			704,331				384,384	(319,947)	14	

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.
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4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	1	DIETARY SALARIES	$	CAREPLUS MGMT INC		$ 0	$	15	
16	V	5	ELECTRICITY		" "		245	245	16	245
17	V	6	REPAIRS		" "		433	433	17	433
18	V	6	MAINTENANCE SALARIES		" "		6,611	6,611	18	6611
19	V	10	NURSING		" "		14,176	14,176	19	14176
20	V	10a	THERAPY SALARIES		" "		3,790	3,790	20	3790
21	V	17	ADMIN SALARIES		" "		29,635	29,635	21	29635
22	V	19	PROFESSIONAL FEES		" "		1,959	1,959	22	1959
23	V	20	DUES/LICENSES/WANT ADS		" "		697	697	23	697
24	V	21	OFFICE SALARIES/EXPENSES		" "		34,190	34,190	24	34190
25	V	23	SEMINARS		" "		575	575	25	575
26	V	24	TRAVEL		" "		64	64	26	64
27	V	25	TRANSPORTATION		" "		726	726	27	726
28	V	26	INSURANCE		" "		2,159	2,159	28	2159
29	V	27	EMPLOYEE BENEFITS		" "		15,030	15,030	29	15030
30	V	30	SL DEPRECIATION		" "		5,348	5,348	30	5348
31	V	32	INTEREST		" "		536	536	31	536
32	V	34	OFFICE RENT		" "		3,266	3,266	32	3266
33	V	35	EQUIP RENT/AUTO LEASE	10,491	" "		4,076	(6,415)	33	-6415
34	V								34	
35	V								35	
36	V								36	
37	V	10a	THERAPY SERVICES		CAREPLUS REHABILITATIVE SERVICES		17,765	17,765	37	17765
38	V	39	ANCILLARY THERAPHY				65,776	65,776	38	65776
39	Total			$ 10,491			$ 207,057	$ * 196,566	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

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STATE OF ILLINOIS

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6C

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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Print Page 6

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STATE OF ILLINOIS

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6D

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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Facility Name & ID Number ROSE GARDEN CONVALESCENT C # 0041780 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	JAKOB BAKST	DIR OPERATION	ADMIN, CONSU	27.83	SEE ATTACHED	2.7	4.58	SALARY	8,476	17-7	2
3	SHERWIN I. RAY	PRESIDENT	ADMIN, FINAN	27.83	SCHEDULES	2.7	4.58	" "	8,476	17-7	3
4	JOE ZIMMERMAN	CFO	FINANCIAL	2.50	" "	2.7	4.58	" "	4,972	21-7	4
5	JANICE CLAFFORD	CONTROLLER	CLERICAL	0.50	" "	2.7	4.58	" "	1,692	21-7	5
6	ROMY MACASAET	RN CONSULTAN	NURSING	1.00	" "	2.7	4.58	" "	3,862	10-7	6
7	JAMEE O'BRIEN	REGIONAL MAN	ADMINISTRAT	2.00	" "	2.7	4.58	" "	4,514	17-7	7
8	TAMMY ORR	RN CONSULTAN	NURSING	2.00	" "	2.7	4.58	" "	4,084	10-7	8
9											9
10	ERIC ROTHNER (HUNTER MGMT LLC)		CONSULTING	27.83	" "		0.16	MGMT FEES	36,000	17-3	10
11											11
12											12
13								TOTAL	$ 72,076		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Previe

the name(s)
PORTS.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT C... Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio	CAREPLUS MGMT	EXTENDED CAI
Street Address	5940 W. TOUHY	5301 W. TOUHY
City / State / Zip Code	NILES, IL 60714	SKOKIE, IL 6007
Phone Number	(847) 647-1717	(847) 674-1180
Fax Number	(847) 647-0222	(847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	559,284	11	$ 97,227	$ 97,227		$	1
2	5	ELECTRICITY	" "	648,651	14	5,352		29,719	245	2
3	6	REPAIRS	" "	648,651	14	9,448		29,719	433	3
4	6	MAINTENANCE SALARIES	" "	648,651	14	144,297	144,297	29,719	6,611	4
5	10	NURSING	" "	648,651	14	309,417	309,417	29,719	14,176	5
6	10a	THERAPY SALARIES	" "	578,314	12	73,756	73,756	29,719	3,790	6
7	17	ADMIN SALARIES	" "	648,651	14	646,825	646,825	29,719	29,635	7
8	19	PROFESSIONAL FEES	" "	648,651	14	42,748		29,719	1,959	8
9	20	DUES/LICENSES/WANT AI	" "	648,651	14	15,220		29,719	697	9
10	21	OFFICE SALARIES/EXPEN	" "	648,651	14	746,225	559,379	29,719	34,190	10
11	23	SEMINARS	" "	648,651	14	12,554		29,719	575	11
12	24	TRAVEL	" "	648,651	14	1,390		29,719	64	12
13	25	TRANSPORTATION	" "	648,651	14	15,846		29,719	726	13
14	26	INSURANCE	" "	648,651	14	47,123		29,719	2,159	14
15	27	EMPLOYEE BENEFITS	" "	648,651	14	328,053		29,719	15,030	15
16	30	SL DEPRECIATION	" "	648,651	14	116,734		29,719	5,348	16
17	32	INTEREST	" "	648,651	14	11,707		29,719	536	17
18	34	OFFICE RENT	" "	648,651	14	71,276		29,719	3,266	18
19	35	EQUIP RENT/AUTO LEASE	" "	648,651	14	88,968		29,719	4,076	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,784,166	$ 1,830,901		$ 123,516	25

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RE MGMT

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Print Page 8

STATE OF ILLINOIS

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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STATE OF ILLINOIS

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

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B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

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B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

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Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number ROSE GARDEN CONVALESCENT CE # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY : ROSE GARDEN CENTER LLC						$	$			$	1
2	AMERICAN NATIONAL BANK		X	MORTGAGE	$28,571.00	09/98	3,600,000	3,150,655	08/2018	7.21	253,096	2
3												3
4												4
5												5
	Working Capital											
6	CAREPLUS MGMT INC	X		WORKING CAPITAL	DEMAND					PRIME +	9,944	6
7	SHAREHOLDER / PARTNI	X		WORKING CAPITAL							49,537	7
8												8
9	TOTAL Facility Related				$28,571.00		$ 3,600,000	$ 3,150,655			$ 312,577	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,600,000	$ 3,150,655			$ 312,577	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Numbe ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	31,510	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	50,679	2
3. Under or (over) accrual (line 2 minus line 1).	$	19,169	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	51,190	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	70,359	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	26,277	8
	1996	26,760	9
	1997	27,457	10
	1998	31,199	11
	1999	50,679	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Numb ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,000 B. General Construction Type: Exterior CEMENT BLOCK Frame METAL BEAM Number of Stories 1-NO BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 16,150
2. Number of Years Over Which it is Being Amortized: 5 YEARS
3. Current Period Amortization: 3,554
4. Dates Incurred: 03/01/96

Nature of Costs: ORGANIZATION EXPENSE

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	400,860	1998	$ 126,500	1
2					2
3	TOTALS	400,860		$ 126,500	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	RELATED PARTY: ROSE GARDEN CARE CENTER				$	$		$	$	$	4
5	110		1998		2,536,069	65,025	39	65,025		149,045	5
6											6
7											7
8	RELATED PARTY : CAREPLUS MANAGEMENT					49		49			8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	COOLER DOOR			1996	1,675	43	39	43		206	9
10	LIGHTING			1997	2,293	59	39	59		233	10
11	PARKING LOT REPAIRS			1998	3,628	242	15	242		605	11
12	BUMPERS/HANDRAILS/ORNAMENTAL RAILING			1999	17,449	447	39	447		566	12
13	CARPET			2000	2,677	20	27.5	20		20	13
14											14
15											15
16	RELATED PARTY IMPROVEMENTS				884,255	22,672		22,672		108,665	16
17											17
18											18
19											19
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21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	CAREPLUS MGMT INC:										33
34	LEASEHOLD IMPROVEMENTS										34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 88,557		$ 88,557	$	$ 259,340	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 21,586	$ 4,260	$ 2,059	$ (2,201)	3-15 YR	$ 4,985	37
38	Current Year Purchases	1,918	274	96	(178)	10 YR	96	38
39	Fully Depreciated Assets							39
40	RELATED PARTY	275,745	48,939	32,922	(16,017)			40
41	TOTALS	$ 299,249	$ 53,473	$ 35,077	$ (18,396)		$ 5,081	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 142,030	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 123,634	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (18,396)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 264,421	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the curre
rental agreement:

	Fiscal Year Ending	Annual Rent
12.	DEC 31/2001	$ #######
13.	DEC 31/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipm $ 28,353 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 44,505	$		$ 44,505	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,418			1,418	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			47,260			47,260	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				50,650		50,650	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2/39-3								12
13	Other (specify): LAB,RENTAL,SUP	39-2				845	28,251		29,096	13
14	TOTAL			$		$ 94,028	$ 78,901		$ 172,929	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,389,173		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,651		6
7	Other Prepaid Expenses	2,433		7
8	Accounts Receivable (owners or related parties)	95,751		8
9	Other(specify): RE ESCROW	2,140		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,517,148	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	10,842		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	27,723		15
16	Equipment, at Historical Cost	23,504		16
17	Accumulated Depreciation (book methods)	(14,178)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	16,150		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(15,935)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 48,106	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,565,254	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 325,083	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,319		28
29	Short-Term Notes Payable	384,500		29
30	Accrued Salaries Payable	24,470		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,423		31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,190		32
33	Accrued Interest Payable	16,572		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 828,557	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	540,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 540,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,368,557	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 196,697	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,565,254	$	48

***(See instructions.)**

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Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 428,067	1
2	Restatements (describe):		2
3	POST CLOSING ADJUSTMENT	(11,967)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 416,100	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(164,403)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(55,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (219,403)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 196,697	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTI # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,050,325	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,050,325	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	3,101	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,101	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 24	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 3,053,450	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 574,312	31
32	Health Care	1,091,606	32
33	General Administration	793,189	33
	B. Capital Expense		
34	Ownership	525,427	34
	C. Ancillary Expense		
35	Special Cost Centers	172,929	35
36	Provider Participation Fee	60,390	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,217,853	40
41	**Income before Income Taxes (line 30 minus line 40)****	(164,403)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ (164,403)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number ROSE GARDEN CONVALESCENT CENTER # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,068	2,110	$ 46,425	$ 22.00	1
2	Assistant Director of Nursing	1,379	1,407	23,922	17.00	2
3	Registered Nurses	13,180	14,165	264,634	18.68	3
4	Licensed Practical Nurses	5,838	6,016	83,163	13.82	4
5	Nurse Aides & Orderlies	42,503	43,633	413,737	9.48	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,957	4,316	65,365	15.14	8
9	Activity Director					9
10	Activity Assistants	4,900	5,050	37,707	7.47	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	120	120	1,972	16.43	13
14	Head Cook	628	652	7,709	11.82	14
15	Cook Helpers/Assistants	18,167	19,351	143,590	7.42	15
16	Dishwashers					16
17	Maintenance Workers	2,917	3,123	30,489	9.76	17
18	Housekeepers	11,706	12,235	89,024	7.28	18
19	Laundry	4,581	4,675	26,880	5.75	19
20	Administrator	1,753	1,789	38,460	21.50	20
21	Assistant Administrator	346	353	6,702	18.99	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,120	9,880	108,057	10.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,163	128,875	$ 1,387,836 *	$ 10.77	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 3,298	1-3	35
36	Medical Director		7,188	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		1,045	10-3	39
40	Physical Therapy Consultant		5,400	10a-3	40
41	Occupational Therapy Consultant		5,458	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		2,687	12-3	45
46	Other(specify)				46
47	PSYCHO-SOCIAL CONSULTANT		0	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 25,076		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ROSE GARDEN CONVALESCENT CEN # 0041780 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JIMMIE STEENBERGER	ADMIN	0.00%	$ 6,539
GERALD BOCK	ADMIN	0.00%	31,921
GERALD BOCK	ASST ADMIN	0.00%	6,702
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 45,162

B. Administrative - Other

Description	Amount
MANAGEMENT FEE	$ 113,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 113,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
CARE PLUS	DATA PROCESSING	8,800
AMERICAN DATA	DATA PROCESSING	2,100
HDSI	DATA PROCESSING	1,244
CARE PLUS	ADMIN CONSULTANT	93,500
KBKB, LTD	ACCOUNTING	25,350
FR & R	ACCOUNTING	1,222
MEYER MAGENCE	LEGAL	14,062
PERSONNEL PLANNER	UC CONSULTANT	2,125
B. JOHNSON D. JACKSON	PROFESSIONAL FEE	9,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 157,403

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,566
Unemployment Compensation Insurance	26,562
FICA Taxes	105,275
Employee Health Insurance	20,430
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	0
EMPLOYEE BENEFITS-OTHER	3,510
EMPLOYEE PHYSICAL EXAMS	0
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 193,343

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	16,516
Health Care Worker Background Chec	1,246
(Indicate # of checks performed)	
ADV & PROMO/MARKETING	3,070
DUES & SUBSCRIPTIONS	4,040
LICENSES & PERMITS	658
TRUST FEES, CONTRIBUTIONS,etc.	107
MGMT CO ALLOCATION	697
LESS TRUST FEES, CONTRIB, etc.	(107)
Less: Public Relations Expense	( )
Non-allowable advertising	(1,258)
Yellow page advertising	(1,812)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,157

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
RELATED PARTY	64
Seminar Expense	
EDUCATION & SEMINAR	1,093
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,157

* Attach copy of IMRF notifications

**See instructions.

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